

Exhibit D

From: Miglio, Terrence J.
Sent: Wednesday, October 01, 2014 5:18 PM
To: Keith Flynn (KFlynn@millercohen.com)
Cc: Buchanan, Barbara E.
Subject: Resser v HFHS
Attachments: HFHS Medical and Psychotherapy Authorizations.PDF \

Please have your client execute these authorizations and return them to us.

Terrence J. Miglio, Esq.

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MRN: _____

Patient Full Name: Reeser Natalie K Maiden Name: _____

Address: Street: 20481 Foster Drive
City: Clinton Twp. State: MI Zip: 48036

<input checked="checked" type="checkbox"/> Disclosed To:	Michigan Legal Copy	<input type="checkbox"/> Requested From:	
	4121 Okemos Road, Suite 12		
	Okemos, MI 48864		
	Address		Address

- 26091 Rev. 4/14

eForm #: HFHS-83-0767MR-1008

MRN: _____

Fill in the appropriate information in each applicable section. Sign and date the form. A separate authorization must be completed for each request.

Address: Street: 20481 Foster Drive
City: Clinton Twp. State: MI Zip: 48036

1. Name or title of person or organization and address to whom information is to be:

2. Specific information to be disclosed / obtained. Indicate date of service:

3. This authorization is valid only if received by Henry Ford Health System within 60 days of the date signed.

4. Ongoing access in treatment settings: This authorization expires when the patient information is disclosed as permitted in this authorization, or on _____ (date cannot exceed one year from the date of signature below).

5. I may revoke this authorization at any time. Revocations to this authorization must be presented in writing. Revocation will not apply to the information that has already been released pursuant to this authorization. Contact Referring Physician Office, One Ford Place, Detroit, Michigan 48202

6. My care or treatment will not be conditioned on signing this authorization.

7. The persons to whom information is disclosed under this authorization may possibly re-disclose the information to others without the patient's knowledge or consent and therefore the privacy of personal and health information may no longer be protected by law.

8. Henry Ford Health System and/or its copying services reserve the right to charge for processing and copying information. This fee is waived when releasing information directly to a treating physician or health care facility.

Signature: _____ Relationship (if other than patient): _____
 Patient, Parent of Minor, Legal Guardian, Personal Representative, Heir at Law, Person under a POA* Date: _____

* If Legal Guardian, Personal Representative or person with authority under a durable medical power of attorney, a copy of appropriate documentation is necessary for release

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